Instructions for Filing Claims

1. Select the type of Claim you are filing.

2. Select Claim Form:
   - Sickness Claim Form (S-2029)
   - Accidental Injury Claim Form (S-00198)
   - Continuing Disability Claim Form (S-13270.1)
   - Home Health Care Claim Form (Form H-C0020)
   - Long-Term Care Claim Form (Form A-14284)

3. Complete Section A: Patient/Policyholder Information. Be sure to include your policy number(s) on all documents.

4. Have your doctor complete Section B: Physician's Statement. If you are filing for disability, your doctor also should complete Section C on Page 2.

5. Be sure to sign your claim form at the bottom of Page 2.

6. Please follow additional instructions under the type of claim below:

You may fax your completed claim forms to our toll-free fax number 1-877-44-AFLAC (1-877-442-3522)
Or mail to: AFLAC Attention: Claims Dept., Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999
For information, visit our web site at www.aflac.com or call toll-free 1-800-99-AFLAC (1-800-992-3522)

Specific types of claims require additional documentation:

- **CANCER**
  - A pathology report diagnosing cancer **must** accompany your first claim for that diagnosis of cancer. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made clinically instead of pathologically, please submit the clinical evidence that established the diagnosis of cancer.
  - Attach an itemized bill showing the diagnosis, services rendered and actual charges for the service.
  - Include a copy of your itemized hospital bill if you were hospitalized.
  - Submit any other bills pertaining to this claim, such as anesthesia, radiation treatments, ambulance, and nurses (RNs or LPNs).

- **SPECIFIED-DISEASE RIDER (DREAD DISEASE)**
  Medical documentation of tissue specimen, culture and/or titer, or other diagnostic studies that initially diagnosed the specified disease must accompany your first claim. Include a copy of your itemized hospital bill.

- **HOSPITAL INDEMNITY**
  - Send us a copy of your hospital bill that lists the number of days confined. Your claim cannot be processed without the hospital bill.
  - A copy of the police accident report is required for all motor vehicle accident claims and other incidents investigated by any law enforcement agency.

- **PERSONAL SICKNESS INDEMNITY**
  Complete and sign the Physician Visit Benefit letter. Benefit letters are sent with the original policy or with the Explanation of Benefits. You also can obtain one by calling **1-800-99-AFLAC (1-800-992-3522)**.

- **INTENSIVE CARE**
  - Please send a copy of your hospital bill that shows charges and the number of days you spent in the intensive care unit.
  - We require a copy of the police accident report for all motor vehicle accident claims and other incidents investigated by any law enforcement agency.

American Family Life Assurance Company of Columbus (AFLAC)
Attention: Claims Department
Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999
For information or help filing your claim, please call toll-free 1-800-99-AFLAC (1-800-992-3522) or visit our Web site at www.aflac.com
Toll-free fax number 1-877-44-AFLAC (1-877-442-3522)

♦ **SPECIFIED HEALTH EVENT**

- Send us a copy of your hospital bill that lists the number of days confined.
- We require a copy of the police accident report for all motor vehicle accident claims and other incidents investigated by any law enforcement agency.
- Submit any other bills pertaining to the claim, such as physical therapy, rehabilitation, home health care, speech therapy, and ambulance.

♦ **ACCIDENT**

- If you were hospitalized, please attach a copy of the hospital bill. Make sure the bill includes your diagnosis and the number of days you were in the hospital. If you were treated in the emergency room or a doctor's office, send us a copy of the bills.
- We require a copy of the police accident report for all motor vehicle accident claims and other incidents investigated by any law enforcement agency.
- Please include a **certified copy of the death certificate** if the patient is deceased.
- Claimant must sign the claim form at the bottom of the second page.

♦ **INITIAL CLAIM FOR DISABILITY**

- **Section B: Physician's Statement** and **Section C: Physician's Disability Statement** (top of Page 2) should be completed and signed by your doctor.
- **Section D: Employer's Disability Statement** (bottom of Page 2) should be completed and signed by your employer.

♦ **SECOND AND SUBSEQUENT CLAIMS FOR DISABILITY** (If you are still disabled and we have already paid you once for this disability) complete the Continuing Disability Claim Form:

- **Section A: Patient/Policyholder Information** at the top of the Continuing Disability Claim Form (Form S-13270.1) should be completed by you.
- **Section B: Physician's Statement** of the Continuing Disability Claim Form (Form S-13270.1) should be completed and signed by your doctor.
- **Section C: Employer's Disability Statement** at the bottom of the Continuing Disability Claim Form (Form S-13270.1) should be completed and signed by your employer.

♦ **HOME HEALTH CARE / ADULT DAY CARE**

- Complete Part 1 and sign the Authorization to Release Information (Form H-C0020).
- Have Part 2 completed by your doctor.
- Have Part 3 completed by the home health care / adult day-care provider, and attach an itemized bill showing the dates, type of services, and charges incurred.

♦ **LONG-TERM CARE/CONVALESCENT CARE**

- Complete Part 1 of the Long-Term/Convalescent Care Claim Form and sign the Authorization to Release Information (Form A-14284).
- Have Part 2 completed by your doctor.
- Have Part 3 completed by the director of nursing at the long-term care facility.
- Attach a bill from the long-term care facility showing the dates of admission and discharge and charges incurred.

♦ **MEDICARE SUPPLEMENT**

- Medicare now files claims electronically. Contact your provider for information about participation in this program.
- Send us a copy of your Explanation of Medicare Benefits form (EOMB).
- When filing for Medicare Part A, please send the Explanation of Medicare Benefits form (EOMB) along with the UB92.

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Attention: Claims Department
Worldwide Headquarters: 1932 Wynnton Road, Columbus, GA 31999
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